THE DISTRICT OF COLUMBIA

HEALTHY PEOPLE 2010 PLAN

A Strategy for Better Health

Executive Summary

Government of the District of Columbia
Anthony A. Williams, Mayor

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September, 2000

I am pleased to present to you a copy of the District of Columbia HEALTHY PEOPLE 2010 PLAN. This Plan provides strategies for improving the health of residents by the year 2010.

The goals and targets in this Plan have been developed to improve the quality of life for each District resident. This means more than the absence of disease. It means maintaining one's physical and mental health.

We are working to improve the health of District residents by expanding our community health programs and increasing access to health care coverage. However, a healthy city ultimately requires personal responsibility. Our residents must understand that they are responsible for maintaining their health and that everyday choices will influence their well-being.

I am committed to the objectives of this Plan and their realization by the year 2010. Through strong public-private partnerships, we can support community health programs and achieve the goals of Healthy People.

I challenge each citizen and city agency to join me in implementing our HEALTHY PEOPLE 2010 PLAN. Together, we can improve the quality of life for children, youth, families and individuals in the District by making health a high priority.

Anthony A. Williams
Mayor

I take great pleasure in introducing the Department of Health's District of Columbia HEALTHY PEOPLE 2010 PLAN. The purpose of this Plan is to set broad goals to improve the health of all District residents. The District's plan is part of a national effort to improve the health of all Americans by the year 2010.

The Plan was developed with input from health professionals and community representatives who set targets for health status improvement that can be reached by the year 2010. This Plan was developed in accord with the federal Healthy People 2010 framework and by obtaining input from local citizens and community agencies. Information was also used from the District's Healthy Residents Year 2000 Plan.

This Plan provides a blueprint for improving the health of all residents of the District of Columbia. A major theme of the national and local HEALTHY PEOPLE 2010 PLAN is to reduce the disparities in health status between races.

The Department of Health will continue to form partnerships with public and private agencies that will enable us to realize the goals of the HEALTHY PEOPLE 2010 PLAN. Our goal is to engage each resident in a collaborative effort to improve his or her own health, as well as that of the family, the neighborhood and ultimately the community.

I encourage all residents and representatives of community agencies to join me in the challenge to close the gap in health status that separates residents and communities, so that life in the District will be healthier and more enjoyable for all who reside here.

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Chief Health Officer for the District of Columbia
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Improve Access to Quality Health Care Services

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PLANNING PROCESS

The HEALTHY PEOPLE 2010 planning process is a national effort to address the major threats to good health and long life for all Americans. The process sets the disease prevention planning agenda for the nation. It's goal is to encourage state health agencies to develop similar plans within their jurisdictions to improve the health status of the community.

The HEALTHY PEOPLE 2010 PLAN for the nation differs from previous disease prevention and health promotion campaigns announced by the Surgeon General in that it focuses on eliminating health disparities among racial and ethnic minority populations. For the major diseases addressed in the Plan, targets are defined according to specific population subgroups. The Plan recognizes differences in disease outcomes among specific population groups as defined by race and ethnicity, gender, age, socioeconomic status, educational attainment, and other variables. Furthermore, it proposes to close the gap in health status between white Americans and Americans of minority origin by 2010.

The District of Columbia Department of Health (DOH) is responsible for recognizing and serving the health needs of District residents. It sets the agenda for disease prevention and health promotion among local residents, whose needs may or may not coincide with those of people residing in other communities. Even within the city, the health needs of the diverse population subgroups of city residents are similar in some instances and divergent in other instances. Consequently, meeting the health needs of the diverse population subgroups among District residents may require DOH program staff to develop a variety of measurable, culturally sensitive, and cost-effective disease prevention and control activities. The District of Columbia HEALTHY PEOPLE 2010 PLAN presents the proposed strategies for closing the gaps in health status among residents.

The DOH mission is to ensure a safe and healthy environment for city residents. This mission drives its development of the District of Columbia HEALTHY PEOPLE 2010 PLAN, which includes the following focus areas:

1. Asthma;
2. Cancer;
3. Diabetes;
4. Disabilities;
5. Emergency Medical Services;
6. Environmental Health and Food Safety;
7. Health Care Finance;
8. Heart Disease and Stroke;
9. HIV/AIDS;
10. Immunization and Infectious Diseases;
11. Injury/Violence Prevention;
12. Maternal, Infant, and Child Health and Family Planning;
13. Mental Health and Mental Disorders;

14. Nutrition;
15. Pediatric Dental Health;
16. Primary Care;
17. Public Health Infrastructure;
18. Sexually Transmitted Diseases;
19. Substance Abuse;
20. Tobacco; and
21. Tuberculosis.

The District's Plan conforms with the federal Healthy People 2010 Plan development guidelines for improving the health of all Americans. Developed by an interagency work group within the federal Department of Health and Human Services and reviewed in a process of regional and national meetings, the following 10 Leading Health Indicators were selected based on their ability to motivate action, the availability of data to measure their progress and their relevance to broad public health issues:

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunization, and
- Access to health care.

The District will also place a special focus on these 10 areas.

The development of the District's Plan was coordinated by the State Center for Health Statistics. Public comment was actively solicited throughout the planning process; and three public hearings were held.

The planning process includes the following steps:

1. Area Profile and Analysis

- Analyze demographic and socio-economic data;
- Review health status data; and
- Review existing needs.

2. Analysis of Federal Guidelines and State Categorical Health Plans and Existing Policies

- Review federal Healthy People 2010 Plan policies and procedures;
- Review District state plans and policies;
- Establish planning group with work group and program liaisons; and
- Conduct status review of the District of Columbia Healthy Residents 2000 Plan.

3. Citizen Participation

- Establish committees and advisory groups;
- Convene public hearings;
- Receive written comments; and
- Review suggested revisions and sanction certain changes.

4. Plan Implementation

- Develop strategies; and
- Develop an annual implementation plan.

5. Monitor and Evaluate Implementation Activities

- Plan submission to the Director of the Department of Health;
- Plan submission to the Mayor; and
- Plan submission to the U.S. Department of Health and Human Services

The focus areas of this Plan are grouped according to the four federal HEALTHY PEOPLE 2010 PLAN objective areas:

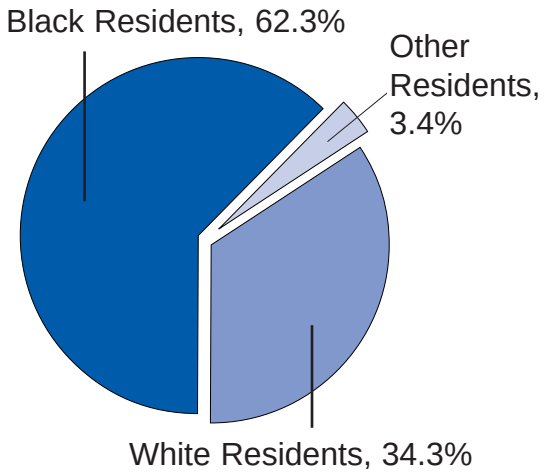
- Promote Healthy Behaviors;
- Promote Healthy and Safe Communities;
- Improve Access to Quality Health Care Service; and
- Prevent and Reduce Diseases and Disorders.

Calendar year 1997 has been chosen as the baseline year for data in this Plan. DOH will produce an Annual Implementation Plan which will be updated each year and contain the latest health statistics for the District.

COMMUNITY PROFILE

As the nation's capital, the District of Columbia is characterized by a distinctive international stature and a diverse population. In its 63 square miles, the District is home to a population which represents many world cultures. The estimated 1998 population of 523,124 is 62.3 percent African American, 34.3 percent white, 3 percent Asian and Pacific Islander, and 0.3 percent American Indian. (Figure 1) Hispanics made up 7.2 percent of the total population. The challenge faced by the District's health system is to address the needs of all its residents, while recognizing the diverse health needs and health status of its numerous subpopulations.

Figure 1: Population by Race, District of Columbia, 1998



Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

In recent years, dramatic changes, in particular the advent of health care management organizations (HMOs), have occurred in the health care arena. These changes have affected the delivery of health care and created new challenges for shaping public health policy. Nevertheless, the purpose for providing health care has not changed. There remains the need to continuously assess

the impact of these changes on public health, on ensuring access to appropriate interventions, on monitoring the overall health system, and on developing appropriate public policy.

In the midst of this changing health care environment, the District of Columbia struggles with a number of health-related problems among its residents. The five leading causes of death in 1998 were heart disease, cancer, cerebrovascular disease, HIV/AIDS, and pneumonia and influenza. Expressed in crude rates, these deaths occurred at rates of 291.1, 258.1, 57.9, 47.0, and 43.8, respectively. Violent crimes, whose victims fill the city's emergency rooms, occurred at a rate of 2,470 per 100,000 population in 1996, almost four times the national rate of 634 per 100,000.The infant mortality rate in 1998 was 12.5 per 1,000 live births compared with 7.2 nationally. Over the past ten years (1989–1998), there has been an overall declining trend in the infant mortality rate (as shown in Table 1 and Figure 2). There were 171 fewer infant deaths in 1998 compared to 1989, representing a decline of 64 percent.

Table 1: Ten-Year Infant Mortality Trends for Residents, District of Columbia, 1989–1998

Year	Births	Infant Deaths	Infant Mortality Rate (per 1,000 live births
1989	11,567	267	23.1
1990	11,806	236	20.0
1991	11,650	235	20.2
1992	10,939	200	18.3
1993	10,614	177	16.7
1994	9,911	180	18.2
1995	8,993	145	16.1
1996	8,377	121	14.4
1997	7,916	104	13.1
1998	7,678	96	12.5

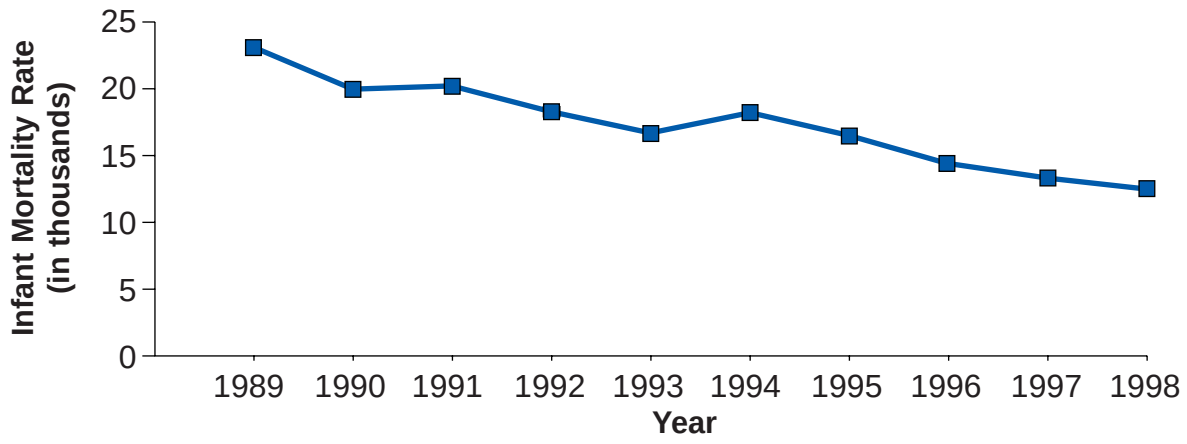
* Only four of five are in large enough numbers to be counted as significant.

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

An important measure of the health of a population is the number of premature deaths. If 65 is used as the age for deaths due to natural causes in the District, then 36 percent of all deaths in the District in 1998 could be regarded as premature (deaths occurring before the age of 65). The leading causes of premature death were cancer, heart disease, HIV/AIDS, and homicide. Furthermore, to quantify the impact of premature deaths, epidemiologists have employed the measure of “years of potential life lost” (YPLL). This measure aggregates the difference between the actual age at death and the age of natural death for all deaths. For the District of Columbia, the YPLL for 1998 was 66,072 years which translates into a YPLL rate of 14,669.0 per 100,000 population.

Improving the health of District residents depends on identifying risks to health, adopting healthy behaviors and lifestyles, and using health services effectively. To reduce risks to health, the community must be protected from communicable diseases and environmental threats. Furthermore, in-depth analysis of health data indicates

Figure 2: Ten-Year Infant Mortality Trend, District of Columbia, 1989–1998



Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

that health problems occur in disproportionate numbers according to gender, race, and socioeconomic status. For example, in 1998, the death rates from the leading causes of mortality in the District were significantly higher for African Americans than for whites; for heart disease, the rate was 365.5 deaths per 100,000 among African Americans versus 176.5 deaths per 100,000 among whites; for cancer, the rate was 325.0 deaths per 100,000 versus 162 per 100,000, respectively. Thus, the goal of reducing or eliminating health disparities among ethnic groups is particularly important in the District of Columbia.

HEALTH STATUS OF RESIDENTS

The health status of a community is measured by key health status indicators. Together with demographic and socio-economic data, health status indicators provide a profile of the community and are the foundation for defining the community's health needs and assessing the manner in which the health care system can meet those needs (Table 2). The adequacy of health status measures is predicated on a clear and concise definition of health. It is necessary to know what is to be measured in order to choose the correct tools with which to measure. The World Health Organization (WHO) has defined health as " a state of complete physical, mental and social well-being." A more generally applied concept of health is the absence of illness, disease and disability which leads to the use of health status measures that indicate the occurrence of illness, disease and disability. Health status measures are derived, in many cases, from indicators of ill-health.

Even though measurements of illness, disease and disability are more accessible than measurements of well-being, problems exist with the availability, validity and reliability of data. Inconsistencies are common in the reporting and recording of illness and disease. Only those diseases are reported that the law requires be reported.

The description given in the 2010 Plan of the health status of District residents is a composite of the available quantifiable measure of life expectancy, natality, mortality and morbidity. For a more detailed discussion of the health status of residents, readers are referred to the complete version of the District of Columbia HEALTHY PEOPLE 2010 PLAN.

Table 2: Health Status Indicators, District of Columbia, 1998

Indicators	Statistics
1. Population estimate	523,124
2. Population 65 year and over	72,710
3. Live Births	7,678
4. Live Birth Rate per 1,000 population	14.7
5. Low Weight Live Births	1,017
6. Births to Teenage Mothers	1,172
7. Births to Unmarried Women	4,829
8. Marriage Rate per 1,000 population	5.5
9. Divorce Rate per 1,000 population	2.5
10. Total Deaths	5,998
11. Crude Death Rate per 100,000 population	1,146
12. Infant Deaths	96
13. Infant Mortality Rate per 100,000 population	12.5
14. Heart Disease Death Rate per 100,000 population	291.1
15. Cancer Death Rate per 100,000 population	258.1
16. Cerebrovascular Disease Death Rate per 100,000 population	57.9
17. HIV/AIDS Death Rate per 100,000 population	47
18. Pneumonia and Influenza Death Rate per 100,000 population	43.8

Source: DC Department of Health, State Center for Health Statistics, Washington, DC.

Promote Healthy Behaviors

Focus Areas:

1. **Nutrition**
2. **Tobacco Use**

1. NUTRITION

The Women, Infants and Children (WIC) State Agency targets low-income pregnant and breast-feeding women, infants, and children for nutrition education and skill-building interventions. It aims to empower WIC Program participants with the knowledge and skills to make informed decisions about the best nutritional choices for themselves and their families.

Goals and objectives for this component focus on lowering iron deficiency in WIC Program participants, promoting breast-feeding, and addressing the problem of overweight in adults among WIC Program participants.

2. TOBACCO USE

Tobacco use is the single most preventable cause of death and disease in our society. Tobacco use increases the risk for cancers, particularly of the lung and oral cavity, cardiovascular and respiratory diseases, and disorders. Smoking during pregnancy increases the risk of low birthweight babies, shortened gestation, respiratory distress syndrome, and sudden infant death syndrome. Efforts to prevent smoking target children and adolescents, since regular smoking usually begins during the teenage years. However, for smokers of all ages, the benefits of quitting smoking are major and immediate, even for persons with smoking-related diseases. In the District, tobacco exacts a

tremendous toll, making it a compelling public health priority.

Goals and objectives for this component focus on reducing the smoking prevalence among adults and adolescents who are current smokers. Other efforts focus on promoting abstinence from tobacco use by pregnant women and provider counseling of patients to quit.

Promote Healthy and Safe Communities

Focus Areas:

3. **Environmental Health and Food Safety**
4. **Injury/Violence Prevention**
5. **Pediatric Dental Health**

3. ENVIRONMENTAL HEALTH AND FOOD SAFETY

The Environmental Health Administration (EHA) became a part of the Department of Health (DOH) in January of 1998 to operationalize the linkages between public health and environmental health. The overarching goals of the EHA are to protect human health; prevent environmental degradation; and promote, preserve, and protect the ecological balance of the District of Columbia. EHA currently manages a variety of inspection programs that directly affect public health and safety, such as lead poisoning prevention, food protection, drug control, radiological health and medical devices, and pesticide certification. These programs also have education and enforcement components.

Goals and objectives of this component focus on containing environmental health threats from waterborne infectious agents and chemical poisonings, air pollutants, radon concentrations in District homes, lead-based paints, and foodborne pathogens, such as Salmonella and E coli. Pharmacies will be encouraged to use linked systems to ensure that consumers are protected from potential adverse drug reactions from medications dispensed by more than one source and to provide all consumers with useful verbal and written information on the proper use of new prescriptions.

EHA has recently assumed responsibility for rodent control. A summary of the current program follows. As one outcome of

the Mayor's 1999 Summit for concerned residents, a new plan for rodent control was developed. EHA was assigned responsibility for implementing the new plan. An Integrated Pest Management Approach was initiated by March 2000. This approach involves: 1) Quality outreach with the distribution of public educational materials; 2) Modified baiting practices; 3) Habitat caging; and 4) Interagency cooperation through enforced referrals to the District's Public Works Sweep Team, and District of Columbia Regulatory Agency inspectors. Program goals and objectives for this new program will be added as soon as they are made available.

4. INJURY/VIOLENCE PREVENTION

The 1994 District of Columbia Health Residents 2000 review states that "Violence and abusive behaviors continue to be major causes of death, injury, and stress in the United States. Baseline data and progress measures for the District of Columbia indicate that violence and abusive behaviors constitute even more of a problem for this city than for the nation as a whole. The 2010 objectives are based on progress made from the 1997 baseline toward the 2000 objectives. They also take into consideration the overall goal to eliminate health disparities among the various population groups.

Goals and objectives of this component will focus on reducing weapon-related deaths and homicides; reducing the rate of suicides; reducing the number of rapes and attempted rapes to women ages 12 and older; and reducing the number of children ages 18 and younger who are maltreated.

Injuries continue to be the second leading cause of death for young persons ages 15 to 24 years and the leading cause of death for African Americans in this age group. Understanding the incidence and prevalence of violence-related injuries in the District of Columbia will create opportunities for the development and implementation of comprehensive and effective prevention measures. Such measures would include data-based prevention activities targeting racially and ethnically diverse groups of all ages, particularly the young. Implementation strategies would be developed in a culturally sensitive and multi-disciplinary approach in collaboration with the local schools, churches, and community of residents.

5. PEDIATRIC DENTAL HEALTH

There has been no oral health assessment in the District of Columbia since 1985. However, it is apparent to practicing pediatric dentists that the District's children, many of whom are underinsured or uninsured, are lacking in the routine dental care that is afforded most of the nation's children. Not only is dental pain the number one complaint in the offices of school nurses, but dental caries (cavities) is the number one preventable disease in children. The Centers for Disease Control and Prevention (CDC) estimates that 20 percent of the nation's children have 80 percent of the tooth decay.

Goals and strategies for this component focus on reducing dental caries in primary and permanent teeth; reducing untreated

cavities in primary and permanent teeth; increasing the proportion of children ages 8 and 14 who have received protective sealants in permanent molar teeth and the proportion of 2-year-olds who receive caries screening by a qualified health professional; and increasing the proportion of all children entering school programs for the first time who have received an oral health screening. Other efforts will focus on ensuring that the District of Columbia has a viable system for recording and referring infants and children with cleft lips, cleft palates, and other craniofacial anomalies to craniofacial anomaly teams.

Improve Access to Quality Health Care Services

Focus Areas:

6. **Primary Care**
7. **Emergency Services**
8. **Health Care Finances**
9. **Maternal, Infant, and Child Health and Family Planning**
10. **Public Health Infrastructure**

6. PRIMARY CARE

The District of Columbia Primary Care Office (PCO) is concerned with the administration of primary care services. The Office supports increasing access to primary care by:

- increasing the number of primary care providers;
- determining the need for new Health Professional Shortage Area (HPSA) designation;
- identifying gaps in service delivery;
- monitoring disparities in health outcomes;
- developing new primary care training sites; and
- monitoring the quality of services being provided.

Goals and objectives of this component focus on increasing access to care by increasing the number of providers (that is, the number of primary care treatment sites) in underserved areas and for vulnerable populations. For quality control, activities will focus on evaluating the impact of new health care programs implemented in 1998 — Medicaid Managed Care expansion, the Children's Health Insurance Program (CHIP)/DC Healthy Families Program, and patients' satisfaction with the services being provided through these programs.

7. EMERGENCY MEDICAL SERVICES

The mission of the Department of Health (DOH) Office of Emergency Health and Medical Services (OEHMS) is to promote the health and well-being of all District of Columbia residents, persons, and visitors by ensuring public access to emergency medical services (EMS), assisting in the development of public and community prevention education initiatives, developing uniform standards of care, ensuring the best patient outcomes, and supporting the continued development of the District's EMS system and the profession of emergency medicine.

The vision for the District of Columbia Government is to achieve an EMS system that is fully integrated with the District's overall health delivery system and with the greater metropolitan region as well. This system will have the ability to identify and modify illness and injury risks, provide acute illness and injury follow-up, and contribute to treatment of chronic conditions and community health monitoring. The system will be integrated with other health care providers and public health and safety agencies, while striving for a more appropriate use of acute health care resources.

Goals and objectives of this component focus on ensuring that all emergency 911 transport units are equipped with advanced life support capability, that standards for response times are well met, and that cardiac arrest survival rates are sustained. A District of Columbia Trauma Registry will be established to capture all relevant data concerning utilization, levels of uncompensated trauma care, and indicators of the quality of trauma care. Efforts will be made in community education for wellness promotion and injury prevention.

8. HEALTH CARE FINANCE

Between 1993 and 1998, significant changes in the infrastructure of the local government had a pronounced impact on health care financing. These changes included the reconfiguration of the District's Medicaid Agency to operate as a component of the newly independent Department of Health, instead of the Department of Human Services; the assigning of day-to-day oversight for many of the key District municipal departments to the Control Authority rather than to the mayor; and the passage of the Balanced Budget Act, with its new programmatic changes for Medicaid. These changes have created a different environment for health care finance than that which existed less than a decade ago.

Goals and objectives for this component focus on expanding insurance coverage for Medicaid to bring more pregnant women and children and adults without children into the health care system; establishing a comprehensive data-reporting system to monitor the utilization of services and quality outcomes; and increasing the percentage of Temporary Assistance for Needy Families (TANF)-related enrollees with a specified source of primary care. Efforts will also be made to increase the proportion of the Medicaid-eligible child population participating in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and to ensure that Medicaid-eligible persons with long-term care needs have access to a continuum of long-term care services.

9. MATERNAL, INFANT, AND CHILD HEALTH

Improving the health of women and their families is a priority for the District's Office of Maternal and Child Health (OMCH), the state Title V agency. This includes monitoring key health and social indicators such as infant, child, and maternal mortality and morbidity.

Goals and objectives for this component focus on reducing death rates for women, infants, and children; reducing severe pregnancy-induced hypertension and eclampsia; increasing the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy; increasing the proportion of very low birth-weight babies born at Level III hospitals, which are facilities for high-risk deliveries and neonates; and increasing abstinence from alcohol use by all pregnant women. Breast-feeding will continue to be encouraged in the early postpartum period.

Goals and objectives for family planning and for adolescents and young adults are included, because there are many overlapping concerns. They focus on increasing the proportion of all pregnancies among women ages 15–44 that are planned and reducing the proportion of repeat unintended births (births occurring within two years of a previous unintended birth). Goals and objectives for youth focus on increasing the use of seat belts and the proportion of teens who refuse to ride with a drunk driver, increasing nonviolent conflict resolution, and reducing teen suicide.

School-based wellness centers will be one mechanism used to achieve the 2010 objectives focusing on youth. These centers will be the anchor for improving accessibility to health care for school-age children through the use of comprehensive coordinated school health initiatives.

10. PUBLIC HEALTH INFRASTRUCTURE

In 1997, the District of Columbia Commission of Public Health became the Department of Health with the responsibility of developing health policy, assessing health needs and enforcing health regulations. These duties can only be accomplished with a public health infrastructure that can provide essential public health services. Meeting this responsibility requires improving the District's public health infrastructure. The DOH recognizes that it will be a major challenge to meet all of the federal Public Health Infrastructure Objectives set out in the federal Healthy People 2010 Plan; therefore, 7 of the 17 national objectives have been selected. These selected objectives are in the information technology and health surveillance categories and are outlined below.

DOH is committed to using information technology and surveillance systems in all of its offices and administrations for internal communications, data collection, and communication of public information, in accordance with the Year 2010 Public Health Infrastructure Objectives. Soon after its establishment in 1997, DOH

began to equip all of its offices and administrations with computer capability and Internet access, and to link all DOH staff by e-mail. DOH has also established a home page (dchealth.com) and have a special section dedicated to the HEALTHY PEOPLE YEAR 2010 PLAN.

The lead agency in this conversion to electronic technology is the State Center for Health Statistics (SCHS).

There are three interactive but discrete components of SCHS that are involved in this process: one is responsible for developing the department-wide electronic information and surveillance systems; the other two for developing statistical surveillance, and the maintenance of vital records and research. The electronic surveillance system under development will enable offices to electronically submit statistical data on DOH program measures for surveillance and quality assurance on a monthly basis by the end of the year 2000.

One application of the department-wide statistical surveillance system tracks program measures from all DOH program offices and administrations; another application tracks health-status indicators for District residents. In 1992, the Centers for Disease Control (CDC) released 18 health-status indicators that are recommended for federal and state agency use in monitoring the health of residents. In the District, data on both the health-status indicators and the program measures will be compiled on a monthly and quarterly basis. At the end of the year, the information on health-status indicators for residents will be aggregated to compute annual rates for each indicator.

Prevent and Reduce Diseases and Disorders

Focus Areas:

11. **Asthma**
12. **Cancer**
13. **Diabetes**
14. **Disabilities**
15. **Heart Disease and Stroke**
16. **HIV/AIDS**
17. **Immunization and Infectious Diseases**
18. **Mental Health and Mental Disorders**
19. **Sexually Transmitted Diseases**
20. **Substance Abuse**
21. **Tuberculosis**

11. ASTHMA CONTROL

Asthma is a long-term, often progressive disease in which the passageways that carry air to the lungs become temporarily blocked. The airways become narrow, and the linings become swollen, irritated, and inflamed. Children may be especially sensitive to such irritants as cigarette smoke, cold air, and airborne particles or chemicals. Allergies to dust, pollen, and mold can also cause asthma.

The District of Columbia has the highest rate of asthma in the nation: more than 5 percent of residents have asthma, compared with less than 2 percent nationally. To combat asthma in District children, the Department of Health (DOH) has launched a Childhood Asthma Campaign. The mission of this campaign is to reduce the morbidity and mortality of pediatric asthma through prevention and treatment, using collaborative partners.

Goals and objectives of this component focus on improving the quality of life for the asthmatic child, promoting an active partnership between the patient and the physician, and identifying barriers to accessing health care. A special study will target asthmatic children ages birth to 11 years in Ward 6, which has the highest asthma mortality rate in the District. (In 1996, eight out of 22 of those dying from asthma in the District lived in Ward 6.)

12. CANCER

Cancer is a chronic disease, the second leading cause of death in both the United States and the District of Columbia. It accounts for one in five deaths in America, and one of every three Americans alive today will eventually develop cancer. In the District of Columbia, more than 3,000 new cases of cancer are reported each year. This translates into one of the nation's highest prevalence rates for cancer.

Goals and objectives of this component focus on reducing mortality from cancers of the lung, breast, cervix, colon and rectum, and prostate through increased screening for early diagnosis, treatment, and related disease prevention behaviors.

13. DIABETES

Diabetes is a significant challenge for the District of Columbia. Many residents have one or more risk factors for the development of diabetes. A Diabetes Control Program has been instituted by the Department of Health (DOH) to address some of the issues and challenges related to diabetes in residents.

Goals and objectives for this component focus on reducing mortality with diabetes as the primary cause; increasing the percentage of diabetic residents who follow recommended procedures for regular hemoglobin A1c and other screening, treatment, and control procedures; and decreasing the incidence of end stage renal disease-diabetes mellitus (ESRD-DM) among diabetic residents.

14. DISABILITIES

No single chapter in the District of Columbia Healthy Residents 2000 Plan addressed health objectives for people with disabilities. This is a new focus area in the District's HEALTHY PEOPLE 2010 PLAN, with objectives that focus on preventing secondary conditions among people with disabilities. Modeled on current Centers for Disease Control and Prevention (CDC) guidelines, the 2010 objectives have been formulated to serve as a guide for the development of public and private programs specifically targeting people with disabilities in the District of Columbia.

Goals and objectives of this section focus on ensuring that all of the District's HEALTHY PEOPLE 2010 PLAN surveillance instruments include a standardized set of items in their core to identify people with disabilities; increasing the participation of people with disabilities in social activities; increasing the number of people with disabilities who report sufficient social and emotional support and satisfaction with life; eliminating disparities in employment rates among people with disabilities and those without; increasing the proportion of children ages 6–21 with disabilities in regular education programs; and increasing the proportion of people with disabilities who report having the assistive devices and skills that they need to fully participate in normal activities.

15. HEART DISEASE AND STROKE

Stroke is the third leading cause of death in the District of Columbia, as it is in the

nation. Stroke is the number one cause of adult disability. African Americans are twice as likely to suffer a stroke as whites or Hispanics. More women die each year from stroke than from breast cancer. However, according to the Stroke Prevention Council, 80 percent of all strokes are preventable. In 1997 the age-adjusted death rate for stroke among residents was 41.4 per 100,000.

Goals and objectives of this component focus on reducing deaths from heart disease or stroke; reducing the proportion of adult residents with high blood pressure; and increasing the proportion of people with high blood pressure whose blood pressure is under control. Adults will also be encouraged to reduce high levels of serum cholesterol and blood cholesterol to normal values.

16. HIV/AIDS

Acquired immune deficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV). The disease is characterized by a weakened immune system, which makes the body susceptible to a number of diseases that the immune system would normally fight off. The first cases of AIDS in the United States, diagnosed in the early 1980s, were primarily among white homosexual men; however, in recent years, the proportion of AIDS cases among this population has declined, while among minority men, women, and injection drug users it has increased. Early in the epidemic, the District of Columbia was reported to have the highest incidence of AIDS per capita in the nation. By 1987, the Centers for Disease Control and Prevention (CDC) had ranked the District fifth in the U.S. among cities in reported AIDS cases, behind New York, San Francisco, Los Angeles, and Houston. In 1996, for the first time, African Americans accounted for a larger proportion of AIDS cases than did whites, and this trend is continuing. In 1998, African Americans accounted for 88 percent of reported AIDS cases, whites 8 percent, Hispanics 4 percent, and Asian/Pacific Islanders 1 percent. The proportion of women with AIDS is also increasing. The Administration for HIV/AIDS (AHA) has aggressively initiated a series of prevention efforts in the community to reduce the incidence of HIV and AIDS and to ensure timely access to HIV counseling and testing and to treatment for sexually transmitted disease (STD).

Goals and objectives in this component focus on lowering the annual incidence of diagnosed AIDS cases among adolescents and young adults, increasing the use of male and female condoms through increased free distribution, and providing more training and capacity-building activities for community-based organizations that offer direct services to high-priority groups. Efforts also will aim to reduce mortality due to HIV infection by increasing the numbers of newly diagnosed adolescents and adults who receive early medical intervention and secondary prevention efforts. Prevention and control activities will include increasing the number of newly diagnosed HIV-positive residents involved in secondary prevention programs and

increasing the number of persons dually diagnosed with substance abuse and HIV/AIDS who are enrolled in drug abuse treatment programs. Other prevention education programs will target children in the classroom, injection drug users, and prisoners in District jails and prisons.

17. IMMUNIZATION AND INFECTIOUS DISEASES

In the District of Columbia, overall progress toward the 2000 objectives relating to childhood vaccine coverage is encouraging, although full immunization (90% or greater) of children under two years of age has not been reached. Of equal concern is the relative lack of progress toward the objectives relating to vaccines used primarily for adults. The only exception is influenza vaccine coverage, which has exceeded the federal Healthy People 2000 objectives. In addition, the major objective for the reduction of perinatal hepatitis B that ensures the administration of HBIG and first dose of hepatitis B vaccine to infants born of hepatitis B positive mothers has been met.

Goals and objectives in this section focus on increasing primary immunization levels in children 19–35 months of age: sustaining/achieving coverage rates of all children in the 19–35 months age range for each vaccine antigen; and maintaining immunization coverage for 95 percent of children in licensed child care facilities. Efforts will also be made to reduce the number of perinatal hepatitis B infections in infants; sustain the elimination of indigenous measles, mumps, and rubella infections and haemophilus influenza type B invasive disease; maintain the low incidence of pertussis cases; and reduce cases of acute hepatitis B to zero in persons under 25 years of age. Plans are being made to increase to 100 percent each new birth cohort enrolled in the Central Immunization Registry.

18. MENTAL HEALTH AND MENTAL DISORDERS

Two data sources were used in the development of the District of Columbia Commission on Mental Health Services (CMHS) Healthy People 2010 Objectives for Mental Health. These were (1) the program area objectives from the federal draft HEALTHY PEOPLE 2010 Objectives for Mental Health (released September 15, 1998) and (2) the District of Columbia Health Residents Year 2000 Plan developed by the District's Department of Health (released August, 1993).

The objectives selected are those most relevant to the Commission's program plans for improving the mental health of District of Columbia residents by the year 2010. Data sources include the Fiscal Year (FY) 1999 CMHS Performance Partnership Block Grant Application, the draft CMHS Work Plan, the draft Objectives of the Receivership, and planned implementation of performance indicators under the State Indicator Pilot Grant.

Goals and objectives for this component focus on expansion of the prevention-oriented services for children and adolescents who experience serious emotional disturbance and increasing the services to homeless people ages 18 and older who experience serious mental illness. Other activities will focus on increasing the pro-

portion of working-age persons among those with serious mental illness who are employed. Issues to be addressed include the development of cultural competence within the city's mental health delivery system; programs to divert seriously mentally ill adults from jail to appropriate community-based services; crisis and ongoing mental health services for the elderly; co-occurring mental health and substance abuse disorders; and an Office of Consumer Affairs and Family Affairs within the mental health system as well as District consumer and family organizations that address issues identified by users of services and their families.

19. SEXUALLY TRANSMITTED DISEASES

Since the 1993 release of the 2000 objectives for the control of sexually transmitted diseases (STDs) in the District of Columbia, progress has been made. However, case rates for Chlamydia trachomatis in the District increased from 137 in 1993 to 574 in 1997. The STD Control Program implemented screening in the STD clinic population and in three Planned Parenthood Service Centers in 1993. The Bureau of STD Control continues to encourage health care providers to screen women for Chlamydia infections.

Goals and objectives for this component focus on reducing the prevalence of Chlamydia infections among young persons (ages 15–24); reducing the incidence of gonorrhea to no more than 150 cases per 100,000 people, particularly the incidence of gonorrhea in adolescents ages 10–19 and in women; and reducing the incidence of primary and secondary syphilis, congenital syphilis, and the human immunodeficiency virus (HIV)-positive rate to below 2 percent among newly tested patients at the Southeast STD Clinic. Other activities will focus on increasing screening and treatment for common bacterial STDs to 100 percent for inmates of youth detention facilities and adult city jails within 24 hours of admission. Efforts will include ensuring that at least 98 percent of the primary care providers treating patients with STDs manage cases according to the most recent Centers for Disease Control and Prevention (CDC) guidelines.

20. SUBSTANCE ABUSE

The Addiction Prevention and Recovery Administration (APRA), formerly the Alcohol and Drug Abuse Services Administration (ADASA), is the state agency responsible for regulating and providing services for the prevention and treatment of alcohol and other drug addictions. Its mission is to prevent alcohol, tobacco, and other drug (ATOD) addictions; to identify, treat, and rehabilitate persons who are addicted and reside in the District of Columbia; and to develop, promote, and enforce the highest quality regulatory standards for delivering services related to ATOD addictions.

Goals and objectives will focus on establishing and implementing a prevention program to educate and enable District of

Columbia youth to reject alcohol, tobacco, and marijuana or other drug (ATOD) abuse through a combination of strategies, including science-based prevention. Efforts will focus on reducing the access of school children to illegal drugs on school property. In the treatment sector, the goal is to reduce the treatment gap for substance abuse by providing increased access to quality care for residents of the District of Columbia, particularly women with dependent children, who are addicted to and/or abusing illegal substances.

21. TUBERCULOSIS CONTROL

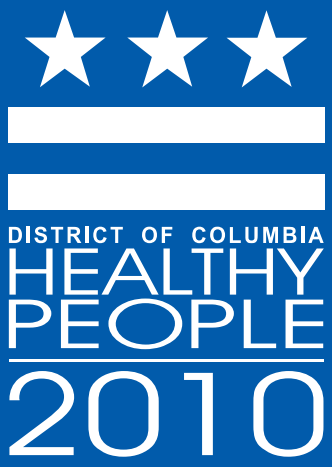
Tuberculosis (TB) disease has become resurgent as a major health problem in the United States since 1985, because of adverse social and economic factors and the impact of the human immunodeficiency virus (HIV) epidemic. Additional contributing factors are multiple-drug resistance and patient noncompliance with recommended procedures for the administration of their prescribed medications.

The reported TB/HIV disease indices continue to affect minorities tremendously, especially African Americans.

A comparison of national and local TB data reflects the District of Columbia's plight regarding the disease; the reports indicate that while the nation has experienced a decrease in the incidence of TB, the decrease in the District of Columbia is of little significance.

Goals and objectives focus on reducing the incidence of tuberculosis in the District of Columbia and increasing the proportion of persons infected with tuberculosis who complete the recommended courses in preventive therapy.

For additional information on any of the HEALTHY PEOPLE 2010 PLAN focus area programs, please refer to the final District of Columbia HEALTHY PEOPLE 2010 PLAN. Additional information and clarification may also be obtained from the responsible program administrators at the District of Columbia Department of Health.



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